Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLUMBIA RIO GRANDE REGIONAL HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name

EMPLOYERS GENERAL INSURANCE

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-98-A999-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "First the per diem rates contained in the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas. Therefore the carrier's adoption of the same are likewise void and unenforceable… In light of the above the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."

Amount in Dispute: $28,734.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "EGIG reimbursed the requestor $$4,472.00 per the provisions of the TWCC Medical Fee Guideline for use effective August 1, 1997… No invoices were submitted for the implant's, and the requestor has not contacted EGIG after submitting the original bill… EGIG requests the TWCC to find that the amount reimbursed is correct, or in the alterative, instruct the requestor to submit the invoices for implants in order that the implants can be reimbursed."

Response Submitted by: Employers Claims Adjustment Services, Inc., 5806 Mesa Drive, Suite 300, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 1997 to November 21, 1997	Inpatient Hospital Services	$28,734.79	$2,849.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 21, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – REDUCTION ACCORDING TO STATE PER DIEM GUIDELINES
   - F – PHARMACEUTICALS GIVEN AT ADMISSION AND GRTR THAN $250 CHRGD PRDOSE WILL BE REIMBURSD AT COST PLUS 10% PER GUIDELINES PG 70.
   - N – IN ORDER TO REVIEW THIS CHARGE WE NEED A COPY OF THE INVOICE DETAILING THE COST TO THE PROVIDER.
   - F – SUBMITTED SERVICES ARE CONSIDERED INCLUDED WITH PER DIEM REIMBURSEMENT.

Findings

1. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was 4 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 4 days yields a reimbursement amount of $4,472. This amount less the amount paid by the insurance carrier of $4,472 leaves an amount due to the requestor of $0.00.
2. Additionally, review of the submitted records finds that the health care provider billed for pharmaceuticals exceeding $250.00 per dose. Per former 28 Texas Administrative Code §134.401(c)(4)(C) “Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%.” However, review of the submitted documentation finds no documentation of the cost to the hospital for the disputed pharmaceuticals. Therefore, no additional reimbursement can be recommended.
3. Additionally, per §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%.” Review of the submitted medical bill finds that revenue code 278 was billed for 11 service units. The itemized statement lists the items provided as 11 units 108M ROD, The operative report states in pertinent part that “we put a pedicle screw in the area of L3-L4 and L4-5 and sacrum, each pedicle at L3, L4, L5, and posterior aspect of the sacrum. We joint them together with rod, osteonic instrumentation. All the instrumentation was done under the control of C-arm and each one was done individually.” The supply invoice for the implantables indicates 3 rod sections and 8 screws. Although the medical bill and invoice indicate 11 service units were billed, review of the operative report and supporting medical records finds that only 3 rods and 4 pedicle screws were documented as having been implanted. The Division determines that 3 spinal rods and 4 screws are supported. The requestor submitted a vendor invoice to support a cost to the hospital of $150.00 per rod x 3 rods = $450.00. 4 spinal screws are supported at $535.00 per screw x 4 screws = $2,140.00. The total cost to the hospital for the supported implantables was $2,590.00. 10% of this amount is $259.00. The Division concludes that cost to the hospital plus 10% for the supported implantables is $2,849.00. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that additional reimbursement is due. As a result, the amount ordered is $2,849.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $ 2,849.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	January 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.